

**OKLAHOMA DEPARTMENT OF CORRECTIONS  
CHRONIC CLINIC RN PROGRESS NOTE**

<b>Date / Time</b>	<b>Reason for visit:</b> Follow – up      Lab results      Compliance      Other _____
	<b>Offender Name / Number:</b> _____ <b>Allergies:</b> _____
	<b>Chronic Clinic(s):</b> _____ <b>Complaints:</b> _____
	<b>Vital Signs:</b> B/P:                  P:                  R:                  T:                  Wt:                  Loss/Gain:
	<b>Pulse Oximetry:</b> <b>Peak Flow:</b> <b>FSBS:</b> <b>Last Seizure:</b>
	<b>Current Medications:</b> _____ _____ _____
	<b>Medication Compliance:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Explain:</b> _____
	<b>Current Lab:</b> _____ _____ _____
	<b>Medical Provider notified of abnormal lab results</b> <input type="checkbox"/> <b>Date:</b> _____ <b>Medical Provider:</b> _____
	<b>Patient Teaching:</b> Diet                  Medication                  Exercise                  Disease Process                  Risks and benefits Goals                  Signs and Symptoms to report                  Other _____
	<b>Method:</b> Discussion                  Demonstration                  Written Material                  Video / DVD                  Other _____
	<b>Evaluation of teaching:</b> Verbalized understanding                  Return Demonstrate                  Reviewed information and tested
	<b>Physical Exam:</b> LOC : _____ Orientation: _____ Pupil size/reaction _____ Specific pain:    YES / NO      If yes, describe _____ Skin color/temp. _____ Edema: _____ Skin turgor:    normal    poor    severe tenting Chest pain:    YES / NO      If yes, describe _____ Heart rhythm _____ Lungs sounds: _____ Cough: YES / NO    Results: productive / non-productive    Oxygen use: YES / NO Abdomen soft: YES / NO    Tender: YES / NO    Bowel sounds: _____ Constipation /Diarrhea _____ Nausea / vomiting: YES / NO    If yes, describe: _____ Urinary symptoms: YES / NO    If yes, describe _____ Other: _____ _____
	<b>Assessment/Nursing Diagnosis:</b> _____ _____
	<b>Plan:</b> _____ _____
	<b>Nurse Signature:</b> _____ <b>Facility:</b> _____